



MON HEALTH MEDICAL CENTER FOUNDATION  
HEALTH CAREER SCHOLARSHIP  
**2024/2025 RENEWAL APPLICATION**

***DUE BY MARCH 1, 2024***

Please print or type all information clearly:

NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Email Cell Phone

NAME OF SCHOOL: \_\_\_\_\_

CURRENT MAJOR: \_\_\_\_\_ STATUS: PART-TIME FULL-TIME

EXPECTED GRADUATION DATE: \_\_\_\_\_

Month and Year

**REQUIRED ATTACHMENT:** Please provide a short statement thanking your sponsor and describe how this scholarship is impacting you.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Return by March 1, 2024:**



Mon Health Foundation  
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